Fort **B**end **R**heumatology **A**ssociates

Patient Name: DOB: ___/___/_____

Health Form

Past Medical History

Please check all that apply:

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer
- ☐ Chronic Back/Joint Problems
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Glaucoma/Cataracts
- ☐ Heart Disease
- ☐ Headaches/Migraines
- ☐ Head injury
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Inflammatory Bowel Disease
- ☐ Kidney Disease
- ☐ Seizures
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Skin Conditions
- ☐ Stroke
- ☐ No Past Medical History

Have you ever been hospitalized for anything other than surgery or childbirth? If so, please explain why.

_____

_____

_____

_____

Fort Bend Rheumatology Associates

Patient Name: DOB: ___/___/_____

Surgeries

Please check if you have had any of the following surgeries:

Cardiac Surgery/Vascular:

☐ Heart Valve Replacement ☐ Heart Bypass Surgery

General Surgery:

☐ Appendix Removed ☐ Hernia ☐ Tonsils Removed

☐ Spleen Removed ☐ Stomach ☐ Gallbladder Removal

☐ Colon

Skeletal/Orthopedic Surgery:

☐ Back Surgery ☐ Bone/Joint Surgery ☐ Fracture Repair

Eye:

☐ Glaucoma Surgery ☐ Cataract Surgery

Female Surgery:

☐ Mastectomy ☐ Lumpectomy ☐ Cesarean Section

☐ Tubal Ligation ☐ Hysterectomy ☐ Ovaries Removed

Male Surgery:

☐ Vasectomy ☐ Prostate Surgery

Have you had other surgeries not listed here? If so, what surgeries?

_____

_____

_____

_____

Fort Bend Rheumatology Associates

Patient Name: DOB: ___/___/_____

Review of System

Check all symptoms that you are currently experiencing. If you have none, please check "None".

General:

- ☐ Recent weight gain ☐ Recent Weight Loss ☐ Fatigue
- ☐ Weakness ☐ Fever ☐ Chills
- ☐ Night sweats ☐ Change in sleeping habits ☐ Change in appetite
- ☐ Swollen Glands ☐ None

Allergic/Immunologic:

- ☐ Seasonal allergies ☐ Urticaria ☐ None

Blood:

- ☐ Anemia/low blood count ☐ Bleeding tendency ☐ Blood clotting problem
- ☐ Prior blood transfusion ☐ Low PH

Ears, Nose, and Throat:

- ☐ Ear pain/discomfort ☐ Ringing in ears ☐ Loss/decreased hearing
- ☐ Nosebleeds ☐ Sinus drainage/congestion ☐ Loss of smell
- ☐ Bleeding gums ☐ Loss of taste ☐ Pain or sores in mouth
- ☐ Dryness in mouth ☐ None

Endocrine:

- ☐ Excessively cold ☐ Tired/ Sluggish ☐ Always thirsty

Gastrointestinal:

- ☐ Difficulty or pain with swallowing
- ☐ Stomach/Abdominal pain
- ☐ Nausea
- ☐ Vomiting

Fort **B**end **R**heumatology **A**ssociates

Patient Name: DOB: ___/___/_____

- ☐ Heartburn/indigestion
- ☐ Bloating/gas
- ☐ Blood in stools
- ☐ Black stools
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Yellow jaundice
- ☐ None

Heart:

☐ Chest pain/pressure	☐ Sudden changes in heart beat	☐ Swollen legs or feet
☐ High blood pressure	☐ Trouble breathing at night	☐ Trouble climbing stairs
☐ Heart murmurs	☐ Pain in legs when walking	☐ None

Kidney/Urine/Bladder:

☐ Difficulty urinating	☐ Pain/burning when urinating	☐ Cloudy urine
☐ Blood or Pus in Urine	☐ Urinary Frequency	☐ Wake at night to urinate
☐ Genital rash/ulcers	☐ Change in urine stream	☐ None

Lungs:

- ☐ Cough
- ☐ Difficulty breathing/shortness of breath
- ☐ Hoarseness
- ☐ Positive TB test
- ☐ Wheezing
- ☐ Spitting up blood
- ☐ None

Fort Bend Rheumatology Associates

Patient Name: DOB: ___/___/_____

Muscles/Bones/Joints:

- ☐ Morning stiffness
- ☐ Muscle weakness/tenderness
- ☐ Muscle twitching
- ☐ Joint swelling
- ☐ Joint Pain
- ☐ Back/Neck Pain
- ☐ None

Nervous System:

- ☐ Headaches
- ☐ Dizziness/fainting
- ☐ Numbness/tingling
- ☐ Loss of coordination
- ☐ Sensitivity/pain - Hands/Feet
- ☐ Memory Loss
- ☐ Tremors
- ☐ Seizures
- ☐ None

Mental Health:

- ☐ Nervousness/anxiety
- ☐ Sleep problems
- ☐ Memory loss
- ☐ Depression symptoms (sad/blue)
- ☐ Mood swings
- ☐ None

Skin:

- ☐ Easy bruising
- ☐ Redness
- ☐ Itching
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness of skin

Fort **B**end **R**heumatology **A**ssociates

Patient Name: DOB: ___/___/_____

- ☐ Nodules/bumps/boils
- ☐ Hair loss/excess hair growth
- ☐ Color changes of hands or feet in the cold
- ☐ None

Eyes:

- ☐ Vision changes
- ☐ Itchy/red eyes
- ☐ Glasses/Contacts
- ☐ Eye pain
- ☐ Eye dryness
- ☐ None

Family History

Please list all problems/conditions of family members (cancer, heart conditions, diabetes, high blood pressure, blood clots, kidney disease, etc.)

Social History

Do you drink coffee? If yes, please state quantity: _____
Do you drink alcohol? If yes, please state quantity: _____
Do you use recreation drugs? If yes, please state quantity: _____
Do you exercise regularly? If yes, please state quantity: _____
Do you smoke/ use tobacco? If yes, please state quantity: _____

Fort **B**end **R**heumatology **A**ssociates

Patient Name: DOB: ___/___/_____

Medications

Please list all medications

Pharmacy information:

If you have any allergies to medications, please list them here and describe your reaction. If none, please write none.